Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Division regarding a medical fee dispute between the requestor and the respondent named above. This dispute was received on 7-21-03.

I. DISPUTE

Whether there should be reimbursement for CPT Code 64721and ambulatory surgical care services.

II. FINDINGS

a. On July 25, 2003, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

b. On 5-7-03, the requestor billed CPT code 64721for carpal tunnel surgery at $850.00. He was paid $382.50. The respondent reduced payment based upon, "C-paid in accordance with affordable PPO." The amount in dispute is $425.00. The requestor did not dispute insurance carrier's position that basis of reduction was per a PPO contract. The insurance carrier did not submit PPO contract documentation to support amount paid. Therefore, 64721 will be reviewed in accordance with the Commission's *Medical Fee Guideline.*

   A review of the submitted EOB indicates that respondent paid CPT code 25116 based upon it being the primary procedure because it had the greater value per Surgery GR (I)(D)(1)(a). Therefore, the MAR for 64721 is 50% of $850.00 = $425.00. The requestor failed to submit medical records to support fee dispute and charges per MFG in accordance with Rule 133.307(g)(3)(B).

c. On 5-7-03, the requestor billed $2,919.75 for outpatient services rendered at Plastic Surgery Center. The insurance carrier paid $1118.00. The respondent reduced payment based upon, "M – In Texas, outpatient services are to be paid as fair and reasonable."

   Section 413.011(b) of the Act states, "Guidelines for medical services must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle in establishing the fee guidelines."

The requestor did not submit documentation to support amount billed was fair and reasonable and complied with Section 413.011(b).

III. RATIONALE

The requestor failed to submit medical records in accordance with Rule 133.307(g)(3)(B) to support fee dispute and challenge insurance carrier's position.

IV. DECISION

Based upon the review of the disputed healthcare services within this request, the Division has determined that the requestor **is not** entitled to reimbursement for CPT code 64721 and ambulatory surgical care services.

The above Findings and Decision are hereby issued this 30th day of December 2003.

Elizabeth Pickle
Medical Dispute Resolution Officer
Medical Review Division